

# ***NAVY MEDICINE***

November-December 1993





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# NAVY MEDICINE

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**COVER:** On Veteran's Day, 11 Nov 1993, the Women's Vietnam Memorial was dedicated in Washington, DC. The bronze sculpture depicting three military nurses and a fallen soldier honors the 11,000 women who served gallantly during the Vietnam War and before now were largely unrecognized. The speaker is Vice President Al Gore. Story on page 10. Photo by HM2 Robert D. Finnemore, NSHS, Bethesda, MD.

# Putting Out the Smoking Lamp

CDR Bruce K. Bohnker, MC, USN  
CAPT James Fraser, MC, USN  
LT Scott Shappell, MSC, USN  
CAPT Steven Hart, MC, USN

NAVY VESSELS HAVE LONG passed the word that "the smoking lamp is out" to protect the health and safety of ship and crew. This call was primarily made because of the risk from exposed flame and smoke during evolutions such as refueling. Similarly, smoking has routinely been prohibited on various parts of ships due to risk of fire, such as the flight deck and hangar deck. Even where permitted, smoking has posed a fire hazard on ships. For instance, the only significant fire on board one aircraft carrier in a recent 18-month period was caused by a cigarette thrown into a wastebasket.

As the medical hazards associated with tobacco have become more apparent, the elimination of smoking in the Navy was entertained. The Secretary of the Navy and Chief of Naval Operations established guidance on smoking prevention and cessation programs.(1-3) In response, Commander Naval Air Force, U.S. Atlantic Fleet (COMNAVAIRLANT) provided additional guidance on smoking cessation programs to all claimancies, including Atlantic Fleet Aircraft carriers.(4) Smoking was permitted only to the extent that it did not endanger life or property, or risk impairing nonsmoker's health. The intent was to

prevent smokers from exposing others to the harmful effects of tobacco smoke.

A number of ships took on long-term goals to become tobacco-free, with the commanding officer of USS *Theodore Roosevelt* (CVN-71) setting a course in 1989 to end smoking by the 10th anniversary of the ship's commissioning, or 25 Oct 1996. That ship had long prohibited chewing tobacco on board due to shipboard sanitation and cleanliness problems. Recently, the Environmental Protective Agency classified environmental tobacco smoke (ETS) as a human lung carcinogen, meaning that exposure to secondary smoke is a health risk.(5) This action





USS *Theodore Roosevelt* (CVN-71)

changed the status of smoking on board Navy ships, since the mere exposure to ETS is a health risk for nonsmokers.

On board *Theodore Roosevelt*, several smoking strategies were implemented to prevent the exposure of nonsmokers to environmental tobacco smoke while allowing smoking on board. These included reduced smoking days, specific smoking hours, and finally limitation of smoking to a few spaces. None of these were deemed sufficiently effective to adequately protect nonsmokers.

Smoking was permitted only in spaces without shared ventilation, leading to the designation of 10 heads

(bathrooms) which vented directly overboard for smoking. Those heads quickly became so choked with smoke that they were no longer fit even for smokers to use. Carbon monoxide levels measured in those heads would preclude personnel from entering the space without an independent source of oxygen. Maintaining sanitation of those heads became impossible, with walls acquiring a thick yellow-brown covering of tobacco smoke residue. It was impossible to prevent smoke from intruding into nearby smoke-free spaces and affecting nonsmokers. Further, one third of the crew transferred every year, thus new smokers were

continually added to the shipboard population. It became obvious that the gradual process would not result in a tobacco-free ship.

The commanding officer published a Commanding Officer's Memorandum of 20 Jan 1993 which accelerated the smoking cessation program. As a former smoker, he was well aware of the difficulties associated with smoking cessation, but he planned for a smoke-free environment for the health of his crew. His actions were fully supported by the commander of the embarked Carrier Airwing Eight, another former smoker. The ship's store stopped selling tobacco products ef-



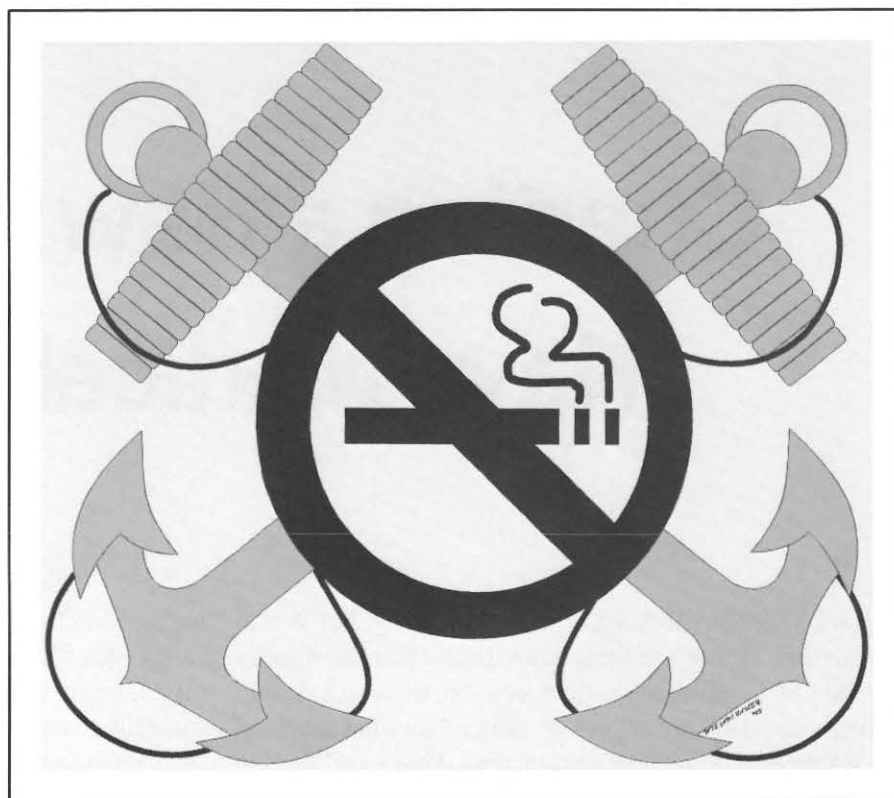
fective 1 March 1993. Meanwhile, *Theodore Roosevelt's* medical department continued to provide smoking cessation clinics and made nicotine transdermal patches available.

*Theodore Roosevelt* put out the smoking lamp on 4 July 1993. After the date, all tobacco products were considered contraband, the possession of which was subject to nonjudicial punishment (NJP). First offenders were offered voluntary enrollment in a medical department smoking cessation course. Second offenders were ordered to attend the smoking cessation course while third offenders received NJP. The commanding officer directed that NJP records would be expunged for offenders with no further UCMJ violations after 90 days; his intentions in the measures were to reform members and not ruin careers.

While not all the crew has been overjoyed with this action, the response has been favorable. Many crewmembers expressed appreciation for the assistance with smoking cessation provided on board. They verbally reported that these measures allowed them to quit where multiple previous attempts had failed.

*Theodore Roosevelt* has received a great deal of attention now that it is a smoke-free ship. The *Navy Times* featured the ship in March and August.<sup>(6,7)</sup> A supporting article noted several other smaller ships have already gone smoke-free. The *Journal of American Medical Association* (JAMA) also spotlighted smoking cessation efforts on board *Theodore Roosevelt*.<sup>(8)</sup>

The smoking cessation program has since grown with other aircraft carriers in the Atlantic Fleet working to eliminate on board smoking. The Navy Surgeon General has made smoking cessation his highest promotion priority.<sup>(9)</sup> Commands have established



Navy Smoking Cessation Logo

smoking cessation programs with their medical departments providing smoking cessation counseling, nicotine transdermal patches, and other medical assistance. The San Diego-based Navy Health Research Center, in cooperation with COMNAVAIRLANT, has implemented a shipboard study of smoking, smoking cessation efforts, and the impact on ship personnel. Results from this study will benefit the entire fleet.

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# Charting a New Course for Navy Medical Education

CAPT David G. Kemp, MC, USN

AVIATORS HAVE A SAYING WHEN FACED WITH a crisis that “There’s nothing more useless than the runway behind you or the altitude above you.” In that spirit, I want to focus on where we are going, rather than what is behind us, for there is no reverse gear on time. I see a real need to more clearly define an overarching philosophy for education and training in Navy medicine, for rational policy must be derived from core values, expressed as doctrine.

The Navy has modified its core doctrine to face the future with reduced resources and a significant change in anticipated mission requirements. This new philosophy is clearly articulated in a document entitled “From the Sea.” The men and women of HSETC (Health Sciences Education and Training Command) must take the lead in developing the education portion of Navy medicine’s new philosophy for health services delivery in the 1990’s. This doctrine will indeed be unique in that Navy medical philosophy will be developed as a congruent element of DOD philosophy, as articulated by the Assistant Secretary of Defense for Health Affairs.

I will emphasize six points which I believe important to consider in developing doctrine. Some may be very tough pills to swallow, but we need to “break out of the box” to get the job done as resources rapidly downsize and our beneficiary population attrites at a much slower rate.

**Point 1: In the Navy Medical Department, education and training are support functions.** Unlike a university where education is the principal mission, we train to satisfy a system need. Navy medical education and training must be geared to provide the right number of men and women, trained with the necessary skills and knowledge, at the right time in their personal career tracks. Too often, we have sponsored both courses and individuals without ensuring

the applicability of the skills and knowledge gained to a long range plan for individual career development, which, in turn, is tied to operational requirements. In short, we do not carefully manage skills and knowledge as a resource at a time when resource management is vital to our survival.

**Point 2: The Navy requires an educated work force, but the responsibility for education is shared between the student and the system.** A bachelor’s level degree is a basic “condition of employment” for most officer commissions. Significant variation exists in this philosophy, however. For example, corpsmen seeking commissions in the Medical Service Corps must obtain the bachelor’s degree on their own time while receiving partial financial support, while the same corpsman seeking a nursing degree receives a relatively greater level of support through a more comprehensive program.

The current philosophy is really one of “supply and demand.” This is most clearly demonstrated through the Health Professions Scholarship Program (our most expensive education program at over \$20 million per year) which provides over 85 percent of our new physicians. Policy regarding the level of support provided has varied widely during my career, based on relative supply and demand. I do not propose any change in the basic tenets, but believe there is room for improvement in fine tuning the present system to achieve greater value for dollar invested.

**Point 3: Navy training programs are conducted mostly in Navy schools, with Navy developed curricula, at Navy expense.** It is in these schools, focused on teaching specific skills to specific work requirements, where we need to think outside our current paradigm. ITRO, the Interservice Training Review Organization, an acronym I didn’t even know when I began my tour, has assumed



increasing importance in consolidating enlisted training programs among Army, Navy, and Air Force. Now, it is hampered by different training philosophies existing among the three services. We in the Navy intuitively believe that we train to a better standard than our sister services and so state, but I know of no data to prove that belief. I believe we must back our beliefs with data in every case where our programs are longer and more expensive. This is really a variant on outcomes research, the new paradigm for assessing quality in health care services, and one in which Navy medicine needs to invest.

**Point 4: Doctrine must be developed regarding freedom of choice in education and training.** In an ideal world, every man and woman would have the opportunity to "be all he/she can be." In a system not governed by the rules of the marketplace, some policy must exist to educate and train members of the force to the needs of the system. We assign recruits to corps school, even when they might prefer to be an electronics technician or a language specialist. In the more recent past, we have begun to assign corpsmen to "C" schools to be trained as technicians in fields not of their choosing, in response to our inability to fill critical needs.

The more difficult challenge now occurs in the training of officers, particularly physicians. We have a crisis in primary care, which will only worsen as we move to a managed care environment. To date, our policy has been confined to limiting specialty training to established requirements and the result, unfortunately, has been more physicians leaving the Navy to pursue postgraduate training in the civilian sector after their obligated service has been completed. Our present system of financial incentives continues to favor specialty training as does the career development pattern. Mandated training in a specialty is not a possibility, for the civilian certifying agencies disavow such policies. We clearly need new ideas.

**Point 5: A new alliance must be forged between formal (classroom) training and on-the-job (OTJ) training.** For most of my tour I have been opposed to "on-the-job training," because of the variation inherent in multiple, uncontrolled training environments. I continue to believe that OTJ is largely uncontrolled as it exists today, but understand that it can, and must, become seamlessly integrated with the classroom. To quote Dr. W. Edwards Deming: "Assembling people in a classroom and giving them lectures can be at best only one-third or one-fourth of the total educational process. A superior must educate his subordinate on a one-to-one basis through actual work. Once the subordinate is educated in this manner, delegate authority to him and let him have the freedom to do his job."

When we have surveyed supervisors regarding the quality of our newly graduate technicians, they routinely complain that the techs do not possess the needed skills to "hit the deck running." Yet, for many of our physicians, the opportunity to participate in residency training (truly on-the-job training) is the primary incentive Navy medicine offers for retention. Why the difference in attitude? Teaching is part of the "physician paradigm"; the Hippocratic oath pledges every physician to teach others what has been taught to him. Is it possible to infect every member of the Medical Department with this same enthusiasm for teaching? I believe that we must attempt this as a future education and training philosophy on a far broader scale than it now occurs. To be effective, this philosophy must extend beyond the staff education and training departments of our hospitals and clinics down to the level of each ward nurse, administrator, senior laboratory, and X-ray technician, etc.

**Point 6: We must instill core values as an element of every curriculum.** At the beginning of my tour, I stated: "If we fail to teach the same values and standards in training that we will require during practice, we cannot expect our former students to remain loyal to the system they enter upon graduation." The lessons of Tailhook have driven home an even greater need to emphasize core values, and we have responded. This is not a task to be confined to the classroom, but a requirement that every member of the education community live through personal example a life reflecting our core philosophy. The student should experience this lifestyle beyond the classroom. He/she should adopt it in the chow hall, in the barracks, everywhere. We must teach more than rules, we must educate students in the moral and ethical foundation which makes this the right behavior.

These are my thoughts as I bring my tour to a close. They may seem too businesslike and not academic enough to suit many. But we are now in a competitive environment. We compete with Army, Air Force, and civilian educational institutions for training contracts. Navy medicine may soon be in competition with "accountable health care plans" for health services delivery for dependents and retired personnel. We must not be content with quality alone; we must seek value, which relates quality to dollars invested. □

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This article is based on a speech delivered at the change of Command upon Dr. Kemp's completion of his assignment as Commanding Officer of the Health Sciences Education and Training Command (HSETC). Dr. Kemp is now Specialty Advisor to the Surgeon General for Internal Medicine.

# Innovations in Alcoholism Treatment

CDR Douglas S. Derrer, MSC, USNR

ON GUAM, "WHERE AMERICA'S DAY BEGINS," the Alcohol Rehabilitation Department (ARD) has been experimenting with some innovative treatment strategies since mid-1990. ARD Guam is a small facility (15 beds, although we have treated up to 20 patients at times) with limited resources in an isolated area with most of the treatment, supply, and administrative problems inherent in those conditions. The ARD believed that traditional treatment strategies had not undergone much progress in recent years and were in need of change in order to better serve the patient population.

Before mid-1990, like most Navy ARDs and ARCs (Alcohol Rehabilitation Centers) the program ran continuously with patients entering treatment each week for 6 weeks of rehabilitation and patients graduating every week who had completed the program (unless they were discharged early for treatment failure). This is called an "open group" format because the composition of the treatment groups changes constantly with the regular, weekly admission and discharge of patients. The open group format has been used for many years in alcohol rehabilitation and other kinds of inpatient psychological treatment. Eighteen of the 19 Navy ARDs currently operate using the open group model<sup>(1)</sup> and this format is similarly ubiquitous in the civilian sector.<sup>(2)</sup> However, there are many problems inherent in this model.

**Problems with the open group format.** The most significant problem is the great difficulty patients and staff

have developing a true sense of "community," specifically, a *therapeutic* community. Usually, the treatment groups are constantly preoccupied with issues of trust, openness, and self-disclosure, seldom progressing much beyond these initial concerns.

At ARD Guam, admitting and discharging patients each week gave the staff too little control over the composition and size of the patient community and the treatment groups. Ward census and group size fluctuated too much, dependent as it was on demand for services and availability of clients. Demand and availability were often at the mercy of the operational commitments of the commands served or of ship deployments. At times there were too many patients so that the ARD's modest bed capacity was exceeded, or too few which weakened the program. As group size fluctuated between these extremes so did therapeutic effectiveness. A "critical mass" of at least six patients per treatment group is necessary for the maintenance of group progress. We found that number very hard to maintain.

**Counselors were experiencing burnout.** They had no visible boundaries governing the number of patients they treated nor the length of time they worked in a treatment capacity. Counselors perceived patients as an endless queue—a discouraging and disheartening perspective. While ARD Guam attempted to rotate its three counselors among two treatment groups and a program administrator position, this was difficult to do in practice. Since groups ran continuously, there was no optimum time to plan for and



effect such rotations. Switching counselors in a group to give one of them a break from treatment always meant disrupting some important therapeutic relationships with patients.

**Why ARD Guam adopted the “closed group” format.** Initially, it was to gain more control over a number of treatment variables. The main reasons for the closed group format were to obtain better control over the vicissitudes of patient census and to reduce counselor burnout. In the 2 years ARD Guam used closed groups during my tenure as Department Head, we learned much about their efficacy and advantages.

Closed group format simply means admitting *all* the patients for a particular rehabilitation treatment cycle at the same time. All patients enter, go through the program at the same rate, and graduate on the same day. The program then “stands down” for 1 to 2 weeks.

During stand-down time preadmission activities for the next treatment cycle take place such as patient screenings, histories and physicals, biopsychosocial assessments, and team meetings. This enables the new patients to be comprehensively evaluated by the counselors, nurse, medical officer, psychiatrist, and psychologist. The stand-down period enables staff to complete assessments, clinical formulations, and individual rehabilitation plans for all patients within the first week of treatment. Doing all workups at the same time gives staff a much better sense of the composition of the patient community than when a few new patients trickled in each week. These are some advantages of the closed group; there are many others.

**Advantages of the closed group format.** The effects of a stable community for a specified period are considerable. When the composition of the patient community is not constantly changing, the establishment and maintenance of a therapeutic milieu is much more effective. Large group and community issues take on greater importance and meaning. They seem to have greater therapeutic impact when the community is stable.

Clear boundaries are advantageous to patients and staff alike. Specific beginning and end points of each treatment cycle reduce staff and patient confusion and uncertainty. Counselors are less stressed when they have definite breaks in the “endless stream” of patients. Staff rotations into or out of treatment can be planned in advance, are logical, and do not disrupt counselor-patient relationships.

The stable composition of the community and its several treatment groups helps patients to build trust rapidly leading to more open communication, self-disclosure, and willingness to reveal and work on problems in group therapy.

Concern has been expressed about having no senior patients available at the beginning of each treatment cycle to help initiate new patients into the program. Our past experience with open group showed this to be a mixed blessing. Senior patients could be effective if they were well engaged in treatment and working with the program. But we have also seen poorly functioning senior patients have a toxic effect on new patients that ran counter to therapeutic goals. In a small treatment setting, the effect of one or two patients, for good or ill, can be powerful.

With the closed group system, we have found that the establishment of group norms, the development of a therapeutic ward milieu, and the socialization of patients into the expectations of the program take place rapidly and most effectively when conditions are controlled by the staff. Detailed rules, regulations, assignments, and program requirements are provided to patients on the first day of treatment. A marathon large group with all patients and staff on the second day of treatment helps to demonstrate what group therapy is about, how it works, and what is expected of patients. This “one-two punch” provides a uniform introduction to the ARD program for all patients, sets clear standards and norms for the remainder of the treatment cycle, and begins to build a sense of community and mutual concern among a diverse collection of strangers. Not unlike the indoctrination of boot camp, the staff is better able to establish and maintain group norms from the outset.

Furthermore, the closed group format consistently produces definable stages of group development and predictable issues of group process. As our experience with and observations of closed group grew over the months, we realized these were highly important and powerful aspects of this format. Group process issues went well beyond chronic concern with trust and openness. Soon it also became apparent that the therapy groups moved through well-defined developmental stages, reflecting a deepening involvement with personal problems and a better engagement with the program. The developmental stages that we have identified together with their associated process issues, defense mechanisms, and affects are tabulated below with an approximate timetable of when they occur during treatment. It should be noted, however, that ARD treatment groups do not progress steadily through these stages but often move back and forth among them. Developmental stages are as follows.

- **First week:** childhood stage—“needy and fearful; resentful.” Basic trust and open communication, dependency, denial. Staff often seen as “punitive parents.”

- **First to second weeks:** adolescent stage—anger,

defiance, rule bending and breaking, “storming.” Authority issues, limit testing, staff splitting, “us and them” conflicts, projection of blame, beginnings of family issues. Staff usually seen as “controlling parents.”

- **Second to third weeks:** adult stage—focus on treatment, internalization of affects, taking responsibility for self. Family and generational issues in alcoholic behavior. Staff seen as “understanding parents.”

- **Third to fifth weeks:** mature (working) stage—acceptance of and working through issues, coming to terms with alcoholism and other personal problems, responsibility for self and others. Staff seen as consultants.

- **Fifth to sixth weeks:** termination stage—“abandonment and loss; consolidation of gains.” Separation anxiety and reentry conflicts, fears and anticipations about returning to the “real world,” reemergence of some issues previously left incomplete; getting it together; facing life without alcohol. Staff seen ambivalently as “rejecting parents” and “welcoming friends.”

- **Post-treatment stage:** aftercare and relapse prevention; patient bonding continues (see discussion of patient cohort below).

With this model, family therapy constructs and metaphors are useful ways to conceptualize and discuss patient issues during treatment, which has been very helpful in clinical supervision. Because of the predictability of these stages and the issues regularly associated with them, the counselors’ understanding and use of group process has improved; yet another benefit of the closed group format.

A strong cohort usually develops among the patients. Because all patients are admitted to treatment, move through its stages at the same time, and graduate together, they have a sense of “common fate” from the beginning which draws them closer together, forming a strong patient cohort or “family.” Patients quickly come to know each other’s problems and weaknesses so that a sense of mutual caring develops. This improved bonding among patients results in a greater sense of responsibility for each other’s welfare. Patients offer each other mutual support during treatment, but more importantly, the development of stronger ties helps to prevent relapse after they have left the program.

Closed group format has worked well to stabilize the treatment program. During the demands of Desert Shield/Storm with ship deployments and rapid changes of orders due to a large drawdown of military personnel from Guam, the patient census could have fluctuated wildly from week to week. This would have been quite disruptive to community stability and the effectiveness of treatment. Having an entire group of patients admitted about every 2

months (rather than a few patients weekly) allowed a reasonable patient census to build up for admission to each treatment cycle, thus, greatly modulating and soothing patient census fluctuations.

**Advantages of stand-down time.** Downtime has been criticized as time wasted since no active treatment is being conducted. In fact, the staff is often busier during downtime than during the active treatment cycle. Downtime has numerous benefits.

- **Provides regular treatment evaluation.** Downtime gives counselors a periodic, planned opportunity to “regroup” and reflect on their work. It gives all staff regular, scheduled periods to evaluate each treatment cycle, conduct a “postmortem” of the treatment phase just completed, and to make systematic changes for the upcoming cycle. Downtime enables staff to develop new programs, lectures, workshops, contact guest speakers, and to make adjustments in the treatment program in view of the assessed needs of the new patient group.

- **Reduces counselor burnout.** While downtime does give counselors a short break from active patient treatment, this in itself does not reduce burnout. Burnout often results from counselors treating patients constantly and having little or no time to consider themselves, their own needs, and what they are doing therapeutically. Downtime reduces counselor burnout because the nature of their jobs changes significantly during this phase. This procedure works especially well in small ARDs where staff and other resources are limited and multiple demands are made on all staff.

- **Simplifies job rotation.** The Department Head is able to rotate jobs among counselors more easily such as program management, family therapy, screening new patients, facilitating groups, lecturing, etc. Rotating counselors into or out of group work for the next treatment cycle becomes easy, logical, and never disrupts any therapeutic relationships.

- **Increases staff efficiency.** Downtime makes admission procedures and physical exams easier and more efficient by grouping the new patients together and seeing them all within a few days to a week. Physicians have indicated this is a better use of their time by concentrating history-taking and physical exams into a short period with a long break (during the treatment cycle) rather than having to work up a few patients every week for admission. All treatment staff make good use of downtime to preadmit patients and to initiate team biopsychosocial assessments, psychological testing, clinical formulations, and individual rehabilitation plans.

- **Improves staff awareness of community issues.** In



open group treatment settings, counselors often perceive patients as "an endless stream," which can be discouraging, contribute to burnout, and reduce a counselor's sense of each patient's individuality. The closed group format enables counselors to think in terms of treatment cycles with specific boundaries (beginning and end points). Such boundaries provide counselors with a better awareness of treatment goals for the patient group as a whole and an improved recognition of patients' progress toward those goals. Counselors begin to think of the new patients as a group, rather than a set of unconnected individuals. They become aware of community issues early in treatment which aids in the development of a therapeutic community.

**Effectiveness of closed group format.** ARD Guam staff is unanimous in their clinical observation that closed group format has more therapeutic impact and is more effective than open group. We have been gathering data for the Naval Health Research Center (NHRC) in San Diego, CA, to test our observations statistically. However, other statistics we have gathered support the improved effectiveness of this program.

July 1990 to July 1991 was the first year the closed group format was operational. Comparing the year July 1990-91 with the previous year (July 1989-90) when the ARD operated with an open group format strongly suggested important changes had taken place. Admissions were up by 10.7 percent. The number of patients completing treatment was up by 26.7 percent. Rehabilitation failures were down by 46.7 percent, boosting ARD Guam's patient completion rate from about 80 percent with open group to over 90 percent with closed group.

We believe these figures reflect improved patient bonding and the more powerful therapeutic impact of a closed treatment community. Admittedly, other variables are confounded with these program changes that could influence the outcomes and might partially account for these statistics. However, we have little doubt that changing the treatment program format to closed group has had a significant and beneficial impact.

**Can closed group restore impact lost by a shorter treatment cycle?** NHRC has been engaged in a Navywide study to determine the effectiveness of 4 week (vs. 6 week) cycles in alcohol rehabilitation treatment. A number of ARDs and ARCs throughout the Navy are participating and have truncated their treatment cycles from 6 to 4 weeks in a controlled manner.

There are important advantages to a 4-week program: cost-effectiveness, more patients treated per year, faster turnaround so that patients are returned to commands more rapidly, and increased emphasis on efficient use of staff and

patient time during treatment. These are important gains to be expected should the 4-week program be accepted and implemented throughout the Navy, as it has been in the civilian sector. However, there may be serious drawbacks to this abbreviated program.

While the NHRC study has not yet reported results, a number of clinicians have expressed concern that the loss of 2 weeks from the treatment cycle will substantially weaken the therapeutic impact of alcohol rehabilitation. Typically, much therapeutic work on consolidation of gains made during treatment and psychological preparation for reentry to the community take place during the last week or two of treatment. Will patients leave treatment feeling "unfinished" and be more vulnerable to relapse with the 4-week program? Clearly, this is one of the important research questions the NHRC study is asking.

Clinical observations from 2 years of closed group format at ARD Guam bear on this question. The increased intensity and power of the program through the development of a therapeutic community was explicated above. Our impression has been that effective management of closed group format can make up for the therapeutic impact lost by reducing rehabilitation to a 4-week treatment cycle. The therapeutic gains of closed group have the distinct potential of offsetting the losses of a shorter program.

To test this hypothesis, ARD Guam requested authorization from BUMED to switch to a 4-week treatment program, which was granted and initiated in January 1992. Additionally, we asked NHRC to assess and analyze this change as a special pilot project to study the effectiveness of a 4-week, closed group format on alcohol rehabilitation. The cooperation of NHRC has been very supportive so that soon enough data will have accumulated to answer these questions. Meanwhile, the staff of ARD Guam continues to make adjustments and accommodations to this more rapid-fire treatment style as we strive to provide quality care for our patients by effectively managing our limited resources.

## References

1. Personal communication, July 1993, LCDR J. Sherrod, MSC, Director, Navy Alcohol Rehabilitation, Bureau of Medicine and Surgery, Washington, DC.
2. Personal communication, July 1993, John Tuner, Ph.D., Acting Chief, Chemical Addiction Rehabilitation Section (CARS), Veterans Affairs Medical Center, Vancouver, WA. □

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Dr. Derrer is currently engaged in duty under instruction (DUINS) as a neuropsychiatry fellow, Psychology Services, Veterans Affairs Medical Center, Portland, OR.

LCDR Mary Nestor gives instructions to two Vietnamese nurses at the Station Hospital, Naval Support Activity, DaNang.



## Women's Vietnam

# Veteran's Memorial Dedicated

THE VIETNAM WOMEN'S MEMORIAL, the first memorial honoring women who served in Vietnam, was dedicated on Veterans Day, 11 Nov 1993. Among the guest speakers were Vice President Al Gore and former Chairman of the Joint Chiefs of Staff, ADM William Crowe. The bronze statue, designed and sculpted by Glenna Goodacre of Santa Fe, NM, was the result of years of tireless efforts by former Army nurse, Diane Carlson Evans. It is located near the "Wall" commemorating those who died in Vietnam. Approximately 11,000 females served in Vietnam; most were nurses. Eight women died there.

The statue depicts four figures, a nurse cradling a wounded soldier, another looking skyward as if anticipating a medevac helicopter, and a

third woman kneeling on the ground. They were deliberately designed without insignia or rank to include symbolically all women who served. The dedication was the culmination of several days of activities including a march by the women down Constitution Avenue.

The best way to convey the emotion generated by the sculpture is to hear from those who either served in Vietnam or cared for the casualties of that war. The following is a collection of memories:

I remember leaning on the rail outside of ICU watching another beautiful sunset over the South China Sea. It was early September 1968, a few days before I was to go home. The beauty of the scene before me and the sound of distant gunfire was an unforgettable dichotomy—tran-

quility and hostility in the same picture. It was much like the year I spent there, I thought, at peace with myself for the job I was doing, but angered by the seemingly endless conflict. Tet in February was exhausting—so many wounded casualties. The decks were lined with stretchers headed for the operating room. Teamwork and concern for the fellow man kept the adrenaline running. We helped a lot of them, but many saw their last sunset no matter what we did. As I walked back into the ICU that evening, I wondered how many more would die before I left. After all, in our 18-bed unit we lost one a day in August. How many more "codes" would we call? —Barbara Coffin Rodgers

Christmas Eve is always a very special time, but one that will remain forever in my mind is 1964. A terrorist bomb exploded in our BOQ, the Brink Hotel in Saigon. Several people were injured, including myself and three other Navy nurses. Two men in the rooms next to ours were killed, and were not





South China Sea: A nurse tends a patient just out of surgery in the intensive care ward of the hospital ship *USS Repose* (AH-16). Below: LCDR Joan Brovilette, one of the operating nurses at the Station Hospital, Naval Support Activity, DaNang and male nurse/anesthetist LT Larry Bergman wheel a wounded Allied serviceman into one of the hospital's nine operating rooms.



found for several hours. When things began to settle down at the hospital, they brought one of the men in that they had just found in the debris. He died on the table next to me, while my leg was being sutured. Shortly after, I went with another nurse back to the BOQ to retrieve some personal articles for our group. The fire was out, and our quarters were destroyed, the area in darkness. When I made it back to my room I could hear Christmas carols. Christmas was a time for Joy and Peace on Earth, yet we were surrounded by sadness, death, and destruction. There is not a Christmas that goes by, that I don't remember my year in Saigon. —Darby Reynolds

I was a "novice" nurse when sent to U.S. Naval Hospital, Yokosuka, Japan, in April 1968. Our patients, mostly marines and

Navy hospital corpsmen, were "fresh from the field." They'd been triaged and initially treated, but were generally a day from the horror. When I think of those 2 years in Japan, I remember all those young men...

- thousands of them
- rows and rows in perfectly lined-up beds on open wards
- serious, sad, scared...desperate...eyes
- some to recover and return to "Nam," more evac'd to the States, once stabilized—many never to recover.

I remember...  
- the open wounds that defy description; how could they survive those wounds?

I remember...  
- the 19-year-old triple amputee who planned to be a sculptor before the war—before he lost both arms and a leg.

I remember...  
- the smell of pseudomonas.  
I remember...  
- the pain of dressing changes.  
I remember...  
- the cries in the night.  
I remember...  
- their nightmares...their memories  
...memories they often couldn't describe; only their tears told.

During those 2 years I learned the senselessness of war and understood the loss of innocence of all who were there. Who listened, who cared? —Mariann Stratton

It was Christmas. The general came aboard the *Repose* for presentation of Purple Heart medals. A handsome young marine dressed in his hospital pajamas



Photo by Rick Reinhard



was seated in his wheelchair. Not a hair out of place, a recruiting poster picture of a marine, above his knees. The mail also arrived on the chopper with the general. Following his medal presentation, the young marine opened his Christmas package from his family. He smiled when he saw the contents, a dozen pairs of heavy socks. His injury—bilateral below the knee amputations.

When I first visited the Wall I didn't know how I would react. Yet here I was, approaching, walking along the lane of names, so many, too many! As I left the Wall I passed the locator desk. I had cared for so many memorable, nameless patients while assigned to the ICU, but one name had always stayed with me. He was a red-headed, freckle-faced young man, so young. He sustained a very serious gunshot wound

**Vietnam Women's Memorial Project Chair and Founder Diane Carlson Evans raises her candle during an evening candlelight ceremony on 11 Nov 1993, celebrating the dedication earlier that day of the Vietnam Women's Memorial on the grounds of the Vietnam Veterans Memorial.**



**Opposite page:** As part of this year's Veterans Day activities, Navy nurses who served in Vietnam visited USS *Sanctuary* in Baltimore, MD. The former Navy hospital ship provided medical care during that war.



Photo by David Klubes

On the helo deck that once brought thousands of casualties to *Sanctuary*, a Maryland Army National Guard "Huey" from the Vietnam era, brings back many memories.

there, nation be damned." I wasn't comfortable with that. I was hoping desperately that we would have an opportunity to see maybe two or three of our old patients. None of us realized how much the Vietnam veterans themselves were a major force behind the statue. The veterans were the ones who came out to see us. Their gratitude was overwhelming.—Carol McKown

My company went to Hill 861, slightly northwest of Khe Sanh. We hit a reinforced regiment of North Vietnamese and were overrun. I remember getting hit and crawling for some distance. I don't remember anything after that. Some time later I came to on the *Sanctuary*. Everything was clean and white and this round-eyed woman was asking me if I wanted ice cream. I hadn't had ice cream in a long time and I was thinking that I wanted all the strawberry ice cream in the world. "I must be dead and this must be heaven," I thought. Many times since then I've thought of those corpsmen and nurses and what they must have gone through. In combat, I had experienced sheer terror. I've been so afraid I wanted to pull the buttons off my shirt just to get closer to the ground. But the combat was intermittent, not constant. What they had was every day, every day, every day. Those people on the hospital ship never had an opportunity to see me like I am now. All they saw were banged up people, not much hope. The folks on the hospital ship never got to see whether their efforts bore fruit, whether their patients actually survived and got better. They saw the middle of a story at its worst and never the conclusion.—Phil Pike, Vietnam veteran □

—Story by David Klubes, *Navy Medicine*, BUMED, Washington, DC.

to his liver, and I had often wondered what happened after he was medevaced. His name was not registered. He made it. We did make a difference.—Joan Bowles Glass

I think I went shopping my first day home from Vietnam. Forty-eight hours before, I was in Vietnam. When I walked around our small town in Pennsylvania nobody seemed to care that American kids were dying in Vietnam—our own kids. America didn't care that we were there and we didn't tell anyone about our time there. The only ones interested were your own family mem-

bers. Everything they say about the welcome home back during those years is true. We weren't welcomed home. But after I got back from the Persian Gulf War and marched in that victory parade down Constitution Avenue, I felt it was the most wonderful experience I ever had in the military. At the time I said, "I'm marching for all my Vietnam people too."—Juel Loughney

I didn't feel comfortable with the women's Vietnam memorial. It was like giving ourselves a birthday party. I thought, "We are going to give ourselves a statue and put it

# Patient Encounter Skills Development

CAPT Frank K. Butler, Jr., MC, USN

ALL OF US IN NAVY MEDICINE ARE COMMITTED to providing the best possible medical care to our beneficiaries. Despite this commitment, we periodically encounter negative comments regarding Navy medicine and military medicine in general both in the media and from our line counterparts. It is difficult to reconcile these unfavorable remarks with the excellent clinical skills possessed by the Navy physicians, nurses, and Hospital Corps staff with whom we work in the hospital. Recently, however, I gained a painful insight into how such negative attitudes may be formed.

An elderly gentleman approached the window in our eye clinic and asked the corpsman at the desk if he could make an appointment to have his eyes examined. The corpsman inquired as to his duty status and upon finding that the patient was a retiree, informed him that our clinic did not see retirees. The gentleman then left in obvious disgust, convinced that the Navy had betrayed his trust and failed to provide him with the medical care which he had been promised. My reaction on hearing this exchange was a sense of profound frustration. This frustration was born of the fact that the information provided by our corpsman was both incorrect and delivered in a brusque, matter-of-fact manner.

In ophthalmology, we see a preponderance of diseases of the elderly. More than 75 percent of the ophthalmology patients that we see on a routine day are the retired patients or their dependents who comprise the majority of our clinic population. Because of the requirement to see active duty and dependents of active duty on a priority basis, however, new "routine" consults for retirees are limited primarily to surgical problems. Emergency consults for retired personnel and their dependents are still seen. The corpsman on duty at the front desk did not take the time to convey these facts in his response nor did he indicate any sorrow for our

being unable to meet the patient's needs or make any offer to help the patient arrange for care through CHAMPUS.

How is such a problem best handled? The traditional Navy approach to dealing with a shortfall in performance is to provide prompt negative reinforcement to the individual responsible. The traditional approach, however, is best avoided in this type of situation. First of all, it just doesn't work. Negative reinforcement may be an effective and appropriate method of improving performance in many military situations, but harsh words are a poor tool with which to fashion a well-informed and compassionate health care provider. The second point is that this approach wastes a potentially valuable asset. TQL (total quality leadership) techniques teach us to obtain the help of the individuals most familiar with a problem in finding a solution.

In reflecting on this issue, several key facts must be considered. In general, the quality of the health care personnel working in a Navy hospital equals or exceeds that of their counterparts in a civilian hospital, but these outstanding professionals must function in a large bureaucracy already burdened with a myriad of regulations and which is chronically overcrowded. Our manpower structure is such that clinic reception and appointment staff are usually junior enlisted personnel. These individuals are required to meet the public, perform preliminary triage, and explain clinic procedures; they must also respond to patient complaints about long waits, shortages in available appointments, and other inconveniences. Our junior corps staff are typically fresh out of high school and "A" school and have had little or no training in public relations skills. It is precisely this relatively weak aspect of Navy medicine which often makes the strongest impression on our patients.

Frequently, patients don't know if their medical condition has been treated optimally. An elderly patient with



glaucoma will not know whether or not our recommendation that he/she have laser surgery is a better or worse choice than treating his/her condition with a different eye drop or proceeding directly to more invasive glaucoma filtering surgery. Patients do, however, know whether or not they have been treated compassionately and courteously by the hospital staff and it is this facet of their care that they remember.

Our department has devised a novel way to approach this problem which has been extremely successful. In the following paragraphs, I would like to describe our methods, demonstrate how they can be applied in a specific situation, and show how they have improved the care that we provide to our patients.

### Step 1

The problem is first outlined to the clinic staff. The importance of conveying the positive, caring attitude that we wish to have our patients remember after their treatment at our facility is emphasized to all department personnel. Our goal of ensuring that patient encounters in our clinic are handled as skillfully as possible is clearly stated and the assistance of the staff in achieving this goal is solicited.

### Step 2

Everyone in the clinic is requested to compose a list of the most frequent or most difficult questions and situations with patients they have encountered in the clinic.

### Step 3

The individual lists are compiled and typed. Our composite list had 16 such questions. Examples included:

"How much longer am I going to have to wait to see the doctor?"

"Why does it take so long for my glasses to come in?"

"I forgot my appointment? Can I get another one?"

"I am a glaucoma patient followed at the Naval Hospital in Jacksonville and I ran out of my medications? Can I get a refill?"

### Step 4

A copy of the composite list is then distributed to each staff member. Each individual in the clinic is requested to take the list home and write down the best possible response that they can come up with for each question. Examples of less desirable responses are also solicited.

### Step 5

Once this has been accomplished, the next step is to review all the suggested answers. We have found it helpful

to talk about the poor answers first, because as the staff discusses why a particular response is not a good choice, they are often pointed toward the best answer. After hearing everyone's suggestion, we then pick what we feel to be the best response to the particular question and write it down. We also list two or three of the less desirable responses to each question as a reminder not to use them.

### Step 6

The list is now retyped with the answers provided and distributed once more to the staff and reviewed for emphasis. These steps are summarized in Table 1.

Let's look at a specific example. A patient presents at our reception desk and says, "My eye is red. Can I see the eye doctor?" Our clinic has a triage protocol for dealing with such situations. If the patient is currently followed in the eye clinic, the corpsman takes a brief history, obtains the record, and relays it immediately to the treating physician. If the patient is not currently followed in the eye clinic, he or she is referred to the hospital emergency room or acute care clinic for primary care. Now, given this basic triage plan, there are still many possible responses which could be made to the patient, but only one best answer. Let's examine some of the bad answers first.

**Bad Answer #1.** "No. You have to go to the emergency room or acute care." This answer is essentially correct but conveys an unsympathetic attitude and lets the patient know that you are only minimally interested in his/her problem.

**Bad Answer #2.** "No, you have to have a consult to be seen in this clinic." This is also a poor choice for several reasons. It implies that the acute care clinic or the emergency room will give the patient a consult to come back and be seen in the eye clinic. In fact, the majority of eye infections are relatively simple episodes of conjunctivitis which are easily handled by a primary care physician, so

**Table 1. Patient Encounter Skills Development Summary**

1. Outline problem
2. List the questions
3. Compile the lists
4. Develop responses
5. Review responses
6. Distribute best responses
7. Periodic refresher and update

the patient may not need to be referred back to be seen by a specialist. In addition, if the patient is already followed in the eye clinic, then she does not need to have a consult to see her doctor.

**Bad Answer #3.** "No, you have to have an appointment." This answer is incorrect because emergency patients are seen without appointments.

**Bad Answer #4.** "Your eye doesn't look all that bad to me." An exceptionally bad choice because in this situation the corpsman is making a diagnostic decision which he or she is not qualified to make.

**Bad Answer #5.** "Yes, wait right here and let me call the doctor." This response is a poor one because it ignores the established triage protocol.

**Bad Answer #6.** "We don't see retirees." This is an undesirable answer for the reasons enumerated previously.

So much for the bad answers. What should the response to this patient be? If the patient is not currently followed in our clinic, the most appropriate answer should probably go something like this: "Mr. Nelson, what we are going to ask you to do is go to our emergency room. Most eye problems can be taken care of by our primary care doctor there. If they feel that you need to be seen by an ophthalmologist, they will arrange a consultation for you and we will be happy to see you. Can I help you with directions to the emergency room?"

In addition to ensuring that the correct information is being conveyed, working through these various responses also provides an opportunity to go over basic communication skills such as responding quickly and cheerfully to the patient's presence at the front desk, listening attentively to the patient's problem, using the patient's name in one's response, and remembering to add "please" and "thank you" where appropriate. Simple things, but they help to create the friendly, consumer-oriented atmosphere that we all appreciate.

Front desk personnel are also reminded of the fact that they are empowered to use their judgment to handle situations which may require special treatment. An example of such a situation may be found in the procedure for dealing with late patients. Our policy is that a patient who is more than 15 minutes late for his or her appointment is requested to reschedule the appointment on another day to prevent inconveniencing all the other patients on the schedule who would be subsequently delayed if the late patient is seen before them. In certain situations, however, it's important for the front desk personnel to realize that they need to make exceptions, such as in the case of patients who have driven 60 or 70 miles for their appointment or a disabled patient who obviously has great difficulty getting

around and for whom a rescheduled appointment would be a great hardship.

Other techniques for dealing with difficult problems may also be discussed, such as the situation where a very difficult patient is encountered at the window or the phone and the patient and the corpsman find themselves becoming frustrated in an attempt to arrive at a resolution to the problem. In this situation it is most appropriate to get up and get another staff person or the clinic leading petty officer to take over the conversation so that tempers do not become short.

Following the initial Patient Encounter Skills Development training, refresher training is held approximately quarterly and the questions are reviewed to ensure that we haven't come up with a better response in the meantime. We also update the list with new questions or situations that have been encountered in the interim. Refresher training is also important because it provides a periodic reminder of our commitment to public relations as well as to quality medicine.

How well do these methods work? We began using these techniques in our clinic last year. Prior to our initiation of Patient Encounter Skills Development training, we were receiving approximately 5-10 complaints concerning rude or discourteous behavior involving clinic personnel each year. For over 18 months now, we have had no complaints regarding rude or discourteous behavior. Informal feedback from our patients has been very favorable. Our Patient Satisfaction Surveys for the past 6 months have shown a 100 percent "excellent" rating by patients evaluating the care that they have received. The increased confidence in dealing with patient problems is obvious in our clinic staff. They now know they are saying the right thing and take great pride in knowing that they are providing service which keeps our patients as happy as possible.

Patient Encounter Skills Development training doesn't take any money and it doesn't take much time. It is a definite morale builder for the staff to share the experiences they have had with patients and try to come up with graceful ways to handle all these difficult situations. As the clinic laughs at how bad some of the poor responses are, it's chilling to realize that almost all these responses have been used at some time in the past. Patient Encounter Skills Development is the single most effective method we have found to ensure that patients leave the clinic convinced that Navy medicine has provided the very best health care possible. □

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Dr. Butler is Chief of Ophthalmology at Naval Hospital Pensacola, FL.



# Naval Medical Research and Development Command Highlights

## • Reducing Coronary Heart

### Disease Risk

Researchers at the Naval Submarine Medical Research Laboratory, Groton, CT, and over 600 volunteer crewmembers of five Trident submarines are involved in a nutrition study combining the unique operational environment of submarines with the goal of substantially reducing coronary heart disease (CHD) risk. Navy shipboard conditions such as confinement, lack of exercise equipment, and the lack of time to exercise are barriers to increasing cardiovascular health in the operational Navy; these conditions are even more severe aboard submarines. Past studies have indicated a trend toward hypercholesterolemia in submariners. The volunteer crewmembers received nutrition education prior to deployment. In addition, the food service personnel are providing submarine crewmembers with nutritionally sound meals which are lower in fat, cholesterol, and calories than the traditional submarine fare. A variety of nutritionally sound choices are offered while maintaining acceptability and palatability. Researchers are monitoring changes in the total cholesterol, high density lipoprotein cholesterol, low density lipoprotein cholesterol, triglycerides, blood pressure, percent body fat, and weight of each volunteer. A reduction of CHD risk factors should lead to improved cardiovascular health and physical readiness while decreasing lifetime medical expenditures and incidences of death and illness associated with CHD. For more information contact CDR Leslie Fenton, MC, NMRDC Research Area Manager for Diving and Submarine Medicine, DSN 295-2610 or Commercial 301-295-2610.

## • First Female Research Volunteers Report Aboard Naval Biodynamics Laboratory

Five female research volunteers reported for an 18-month tour of duty at the Naval Biodynamics Laboratory (NBDL), New Orleans, LA. These women join their male counterparts in helping researchers study the effects of impact acceleration and ship motion on Navy and Marine Corps personnel. Current impact studies investigate potential injuries from the effects of indirect forces on the head and neck. These studies include the use of 700-foot horizontal accelerator and a 36-foot vertical accelerator. The horizontal accelerator is used to obtain data for human response to simulated crashes and the vertical accelerator allows a more realistic investigation of the biomechanical effects of forces similar to those produced by an aircraft ejection seat. The vertical accelerator is also used to simulate forces encountered aboard Navy ships during underwater explosions. Volunteers are initially exposed to

low levels of acceleration which are increased in increments of a single "G" within a well-established safety range. Before, during, and after each test, a data acquisition system is used to collect and analyze inertial and physiological measurements. The ship motion simulator (SMS) and a tri-axial tilt/rotation chair with a visual effects device also are used to study the effects of motion on physical and mental performance. NBDL's ship motion simulator is capable of creating ship motion in conditions up to sea state five with three degrees of freedom: heave, pitch, and roll. For more information contact CDR T. Singer, MSC, NMRDC Research Area Manager for Aviation Medicine and Human Performance, DSN 295-0878 or Commercial 301-295-0878.

## • NAMRL Researcher Wins FY95 Accelerated Research Initiative Award

A distinguished panel of scientists met at the Naval Medical Research and Development Command, Bethesda, MD, to review research proposals competing for FY95 funding as a 6.1 Accelerated Research Initiative (6.1 is basic research directed toward increasing essential fundamental scientific knowledge of broad benefit to naval operational needs and technology applications). The panel selected the proposal, "Virtual Environment Displays in Acceleration Environments," presented by CDR Angus Rupert, MC, a researcher at the Naval Aerospace Medical Research Laboratory (NAMRL), Pensacola, FL. The panel recommended an initial 3-year, \$550K per year award. Virtual environments are synthetic environments that can be influenced by the interactions of the user; for example, a pilot might control the motion of remote physical objects or influence the events of a flight simulation. The problem addressed in CDR Rupert's proposal is that human perceptual and motor responses may be very different in virtual-dynamic environments than in virtual-static environments (the standard condition for virtual environment testing). Initial studies indicate that using virtual displays during certain kinds of acceleration may distort a pilot's perception of orientation and velocity. In order to develop techniques to minimize the distortion, this research will attempt to characterize these misperceptions and then identify parameters that cause these illusions. The advent of virtual reality technology and its projected future use in the fleet make this the time to do such basic research. The work should benefit the Navy, DOD, NASA, and the civilian sector. For more information contact CDR T. Singer, MSC, NMRDC Research Area Manager for Aviation Medicine and Human Performance, DSN 295-0878 or Commercial 301-295-0878.

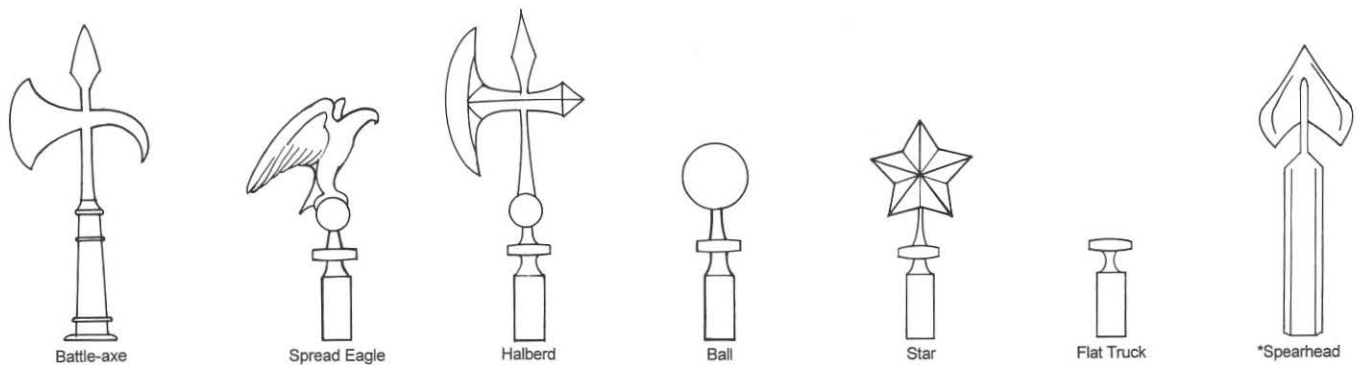


Diagram 1

\*Note: This ornament is intended for the guidon, not the flag of the U.S. Marine Corps.

# The Innocent Flame of Ignorance

HMC(PJ) Joe K. Falkenberry, USN

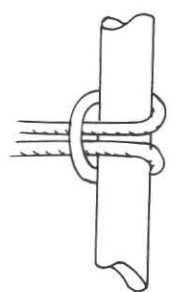
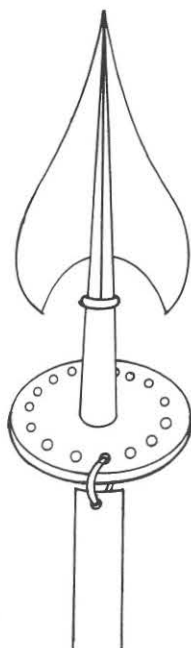


Diagram 2  
Larks Head Knot

Diagram 3 (Right) Spearhead, with streamer set attachment, for the flag of the U.S. Marine Corps. Note: When streamers are authorized cord and tassels are not used.



WHEN THE ISSUE OF FLAG-BURNING began,, it made me very angry. I suddenly realized that I had not given much thought to our nation's flag; now I do. As my work required travel to different commands, at each of them I would notice how their flags were displayed. The fact that these displays were never the same prompted me to find out why.

After reviewing Navy and Marine Corps regulations concerning flag displays, I have discovered that all flag displays are supposed to be identical. The Navy, Marine Corps, and Coast Guard use one basic reference in addition to specific instructions and orders concerning flags—the Naval Telecommunication Procedures publication NTP 13(B), *Flags, Pennants, and Customs Manual*. The NTP 13(B) describes how quarterdeck flags are to be displayed as well as how flags are to be flown outdoors. My discussion of these

two topics will be limited to the discussion of displays at shore commands within the boundaries of the United States, and I will refer to the flag of the United States as the national ensign.

## Quarterdeck

Rarely does the national ensign stand alone on the quarterdeck; other flags are displayed as well. "The staff ornament for the national ensign, when displayed from other than in boats, shall be the battle-axe" (NTP 1102a.). The battle-axe (Diagram 1) is displayed with the cutting edge facing forward. The only cord and tassels authorized for the national ensign are the red, white, and blue cord and tassels (NTP 1723a.), which is fastened just below the battle-axe with a Larks Head Knot (Diagram 2). The red, white, and blue cord and tassels are available through the Defense Logistics Agency. The ends of the cord



and tassels, like the flag itself, are to fall freely and equidistant from the knot. The national ensign should never touch anything beneath it (NTP Annex A Sec.4.). The same holds true for the display of the national ensign by the Marine Corps; the national ensign "will be displayed in accordance with the provisions of U.S. Navy Regulation" (NAVMC 16-1.a. & MCO Sec.C1.a.). No flag shall occupy the position of superior prominence, which is the national ensign's right, the observer's left.

The proper display of the organizational flags of the Navy and Marine Corps is as follows: The flag staff ornament for the Navy flag shall be the battle-axe (NTP 1103), cutting edge facing forward. No cord and tassels are authorized for use with the Navy flag (NTP 1710d.). The flag ornament for the Marine Corps flag is the spearhead (Diagram 3), the edges shall be aligned fore and aft. The Marine Corps flag is authorized to have scarlet and yellow cord and tassels (NTP 1723a. & MCO Sec.E2.d.) which are also fastened below the flag staff ornament using a Larks Head Knot. The Marine Corps flag, then the Navy flag, will take the place of honor next after the national ensign (NTP 1724). The use of fringe on the national ensign, Navy flag, and Marine Corps flag is authorized; it is not incorrect to display a flag without fringe with flags that have fringe.

There are a number of other authorized flags that can be found along with the Navy and Marine Corps flags. If there are no guidelines as to which flag staff ornament should be used to top the flag staffs of these flags, the Advanced Signal School recommends that the battle-axe be used since it is the most appropriate of all flag staff ornaments. If a flag has no order of precedence, it should be placed in the last position; cord and tassels and fringe may or may not be authorized. Generally speaking, the display of flags outdoors is not as involved as it is for indoor display.

## Outside

The four flagpole configurations that can be found at individual commands are: the flagpole, the flagpole with crosstree, the flagpole with gaff, and the flagpole

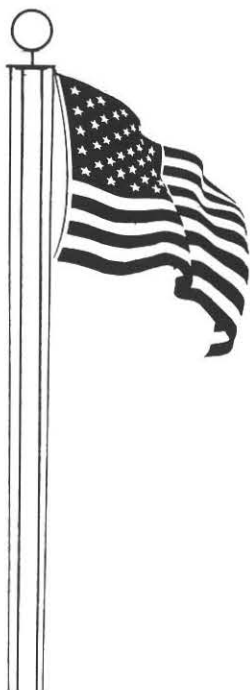


Diagram 4

As seen looking from the entrance of the headquarters building to the flag pole. Half-mast position shown at right.

with crosstree and gaff. All shall be topped with a ball of an appropriate size (NTP 802). "The right side of a flagpole is determined by looking from the main entrance of the headquarters building to the pole" (NTP 801b.). If the peak of the flagpole or gaff is equipped with two halyards the national ensign will be displayed for the right halyard. When dis-

played, the POW/MIA flag shall be attached directly beneath the national ensign (NTP 1709c.).

From a flagpole, the national ensign is displayed from the peak of the pole, the half-mast position is three-fourths of the way to the peak, no personal flag is displayed (Diagram 4). From a flagpole with a crosstree, the national ensign is

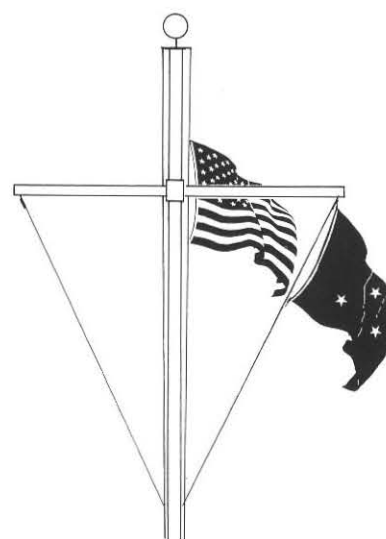
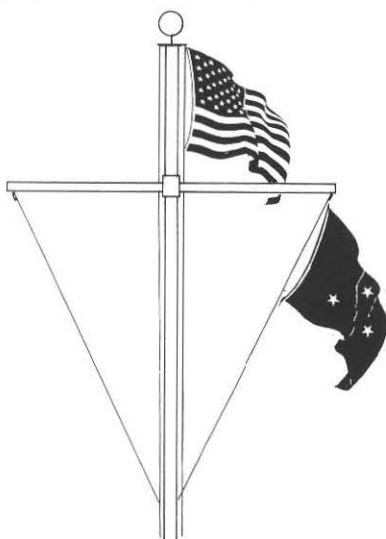


Diagram 5

As seen looking from the entrance of the headquarters building to the flag pole. Half-mast position shown at right.

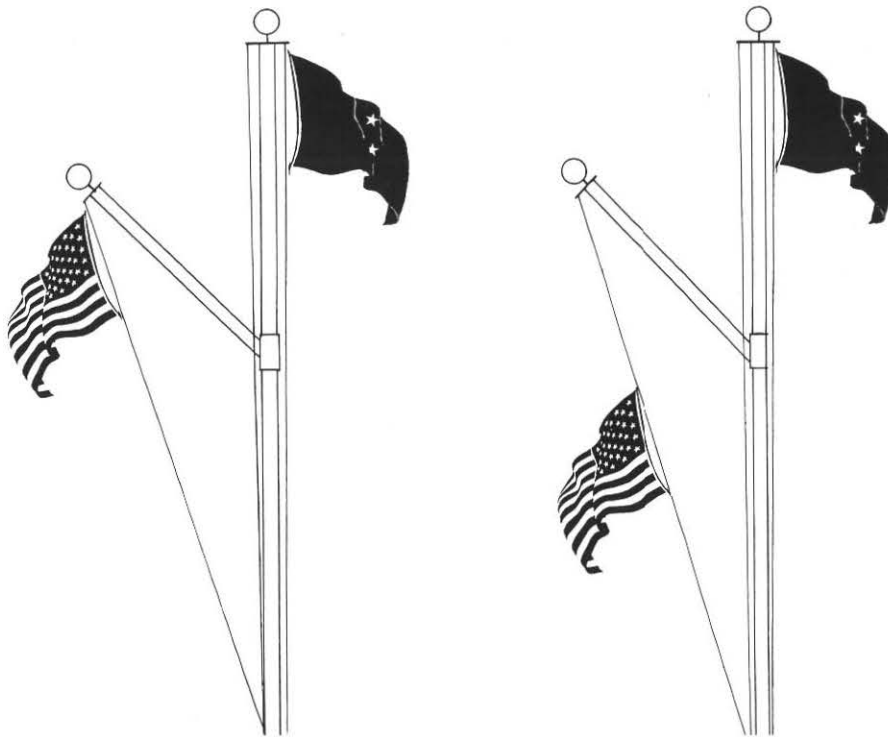


Diagram 6

As seen looking from the entrance of the headquarters building to the flag pole. Half-mast position shown at right.

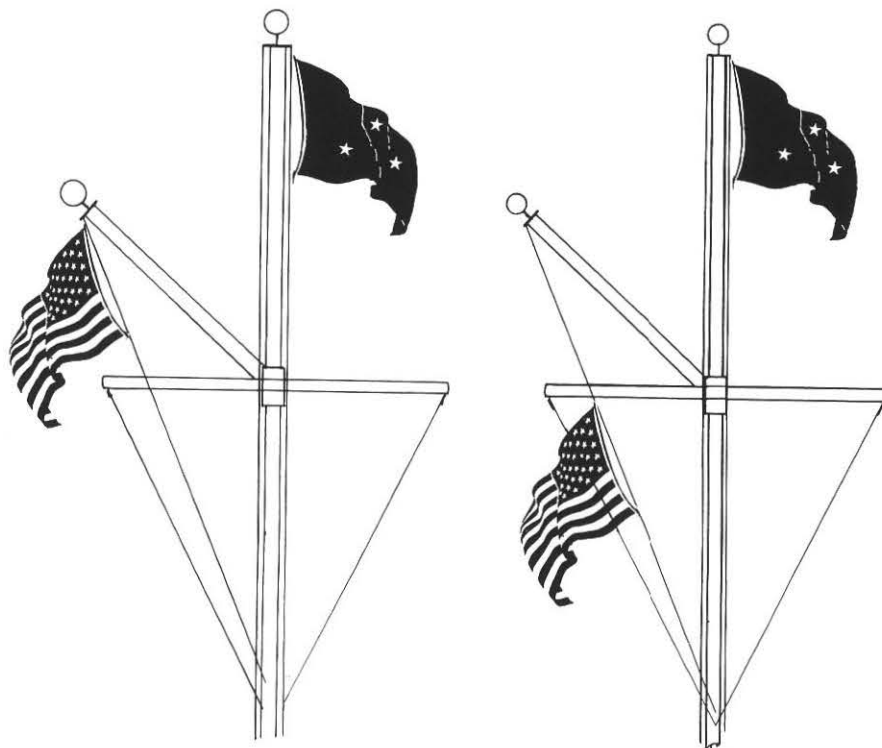


Diagram 7

As seen looking from the entrance of the headquarters building to the flag pole. Half-mast position shown at right.

displayed from the peak of the flagpole, the half-mast position is with the "bottom of the union portion even with the crosstree" (NTP 801b(2)), the personal flag is displayed from the outermost halyard of the right hand crosstree (Diagram 5).

From a flagpole with a gaff, the national ensign is displayed from the peak of the gaff, the half-mast position is halfway between the top and bottom of the gaff, the personal flag is displayed at the peak of the flagpole (NTP 801b(3)) (Diagram 6).

And last, from a flagpole with crosstree and gaff, the national ensign is displayed from the gaff, the personal flag is displayed from the peak of the flagpole (Diagram 7).

If you think you have more pressing issues to deal with than flag displays, stop for a moment and think about what our flags represent. Our flags are living symbols of the men and women who have served and sacrificed in the service of our country. They represent the achievements of the men and women serving today; they represent you. This is not so much an issue of attention to detail as it is an issue of pride and self-respect. The amount of time required to ensure that our colors are displayed correctly is negligible. Educating ourselves in the correct display of our flags is important, especially for enlisted personnel. It will be the enlisted sailor or marine who will move quarterdeck flag displays for command functions and cleaning, who will be hoisting the flags on command flagpoles.

For assistance in answering questions not specifically addressed in the NTP 13(B), contact the personnel at the Advanced Signal School in Virginia at DSN 564-3842, they will give you prompt, friendly service.

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# Navy Medicine

## November-December 1943

Jennifer Mitchum

DECEMBER MARKED THE SECOND anniversary of Pearl Harbor. Since then, the Allies mounted an effective defense, denying the enemy Australia and evicting the Japanese from several Pacific islands including Tulagi, Guadalcanal, and New Georgia. Moreover, Allied forces had captured parts of New Guinea. Many miles north, American forces had also reclaimed the Aleutians. In the latter part of October, Allied forces also seized the Treasury Islands to the south of Bougainville. In the Pacific, the war had notably changed from defense to offense.

Similarly, in the Mediterranean theater, the Allies had driven the Germans and Italians out of North Africa. In July and September 1943, the Allies successfully invaded Sicily and Italy, respectively. As a result, Italy capitulated in September 1943.

### Bougainville

Bougainville Island was the last Japanese stronghold in the Solomons. By controlling Bougainville, Allied planes could constantly attack Rabaul and prevent the enemy from supporting its bases on New Guinea and New

Britain. Allied troops landed halfway up the west coast of Bougainville on the morning of 1 Nov. Although the area was swampy and offered no satisfactory anchorages, it wasn't heavily defended.

### Navy Medicine Ashore

Three medical companies of the First Marine Amphibious Corps and the headquarters company of the Third Medical Battalion, landed with the invasion troops and established three field hospitals between 1 and 13 Nov. One 400-bed hospital unit was set up within hours after landing. The company "E" medical facility, set up 7 Nov, served as the division hospital.

### Battle Casualties and Disease

In taking Bougainville, there were 276 Allied troops killed, 94 missing, and 1,097 wounded.(1) In comparison, the 30,000-man Japanese force suffered 13,000 fatalities; 3,000 were killed in action and the rest died from malaria, beriberi, dysentery, and tetanus.(2)

Disease incidence was relatively low among Allied troops with 5,004 cases reported.(3) The two main groups

needing treatment were those who had acquired diseases prior to coming to Bougainville and those suffering from combat fatigue and "war neurosis." For instance, all the 296 malaria cases were the result of previous exposures.(4) Medical personnel issued large doses of Atabrine as a suppressant and treatment.

The low incidence of malaria resulted from effective control measures—construction of roads, sewage systems, use of aerosol-pyrethrum, etc.—and not because the island was less malarious.(5) Similarly, troops who had been in Samoa showed a high incidence of filariasis; 92 cases were reported.(6) The First Corps Medical Battalion also treated 24 cases of gas gangrene in which six deaths occurred.(7) Mob-8 on Guadalcanal reported 20 cases, with one death.(8) The majority of the personnel experienced mild diarrhea and 103 had dysentery, but the use of sulfonamide reduced the duration and severity of both.

The largest number of casualties on Bougainville suffered from either "war neurosis" or combat fatigue. Combat fatigue cases totaled 749 and war neu-

A jeep ambulance moves along a Bougainville beach carrying wounded marines from the front lines to field hospitals. Even these sturdy vehicles, equipped with chains, had to give way to amphibious tractors because of the mud and dense jungle growth reaching down to the waters edge and almost impenetrable swamp inland. The jeeps carried wounded for short distances to designated spots where their patients were transferred to the tractors.



rosis cases totaled 140.(9) The First Corps Surgeon described combat fatigue cases as those in which the men were dazed or confused but could be temporarily rehabilitated and returned to duty although they may have broken down again later under combat conditions. War neurosis cases were described as those men who became a menace to themselves and others and needed to be sent out of the combat zone for rehabilitation.

### Navy Hospitals

Many wounded leaving Bougainville and other points were transferred to Navy medical facilities on Guadalcanal, Vella Lavella, and other islands in the Central and South Pacific. Mob-8 on Guadalcanal continued to serve as the focal point for Navy medicine in the Solomons. At Mob-8, medical personnel rendered final treatment to some patients and prepared others either for evacuation further south or Stateside. Between 1 June and 31 Dec, 11,105 patients were treated at Mob-8; 5,343 were evacuated from there. The majority, 4,527, left by ship.(10)

In New Zealand, medical personnel at Mob-6 in Auckland received and treated 747 patients.(11) At Base Hospital No. 4 in Wellington, 118 and 485 patients were admitted in November and December, respectively. Between the time it was commissioned in March and year's end, 8,960 patients had been admitted.(12) Combat casualties continued to arrive, but in fewer num-

bers. There were also fracture and burn cases. Malaria, however, was the worst problem. Clinical symptoms of malaria often recurred in patients, in some cases up to 10 times. Patients were given 2 weeks of therapy with quinine and Atabrine.

The patient census of Mob-7 Noumea, New Caledonia, reached a year high on Christmas Eve with 1,626 patients in the hospital. By year's end, Mob-7's total capacity hovered slightly over 2,000.(13)

### Penicillin in the Pacific

In November, medics at Mob-5 Noumea, New Caledonia, used penicillin to treat a patient stricken with osteomyelitis with multiple wounds.(14) This was believed to be the first time penicillin was used in the South Pacific. Following that incident, penicillin was the treatment of choice with several diseases and injuries. Subsequently, medical personnel forwarded results to BUMED to aid headquarters in its evaluation of "the wonder drug."

Similarly, Base Hospital No. 3, Espiritu Santo, New Hebrides, treated 41 cases with penicillin.(15) Medical personnel administered the drug by

I.V. and intramuscular injection. In six of the cases, the patient's conditions did not respond to the drug. Nonetheless, penicillin proved effective in treating gonorrhea and blood stream infections. With penicillin now available in increasing amounts, Allied medical personnel would no longer have to depend solely on the less effective "sulfa" drugs.

### The Gilberts

Early in 1942, Japanese forces seized the Gilbert Islands in the Central Pacific. By the close of 1943, however, Allied forces were in a position to win them back. Conquest of the Gilberts would provide the first stepping stones on the way to Tokyo. The first target in the Gilberts was Tarawa Atoll. Subsequently, they would invade Makin.

### Tarawa

Described by some historians as "the most heavily defended atoll that would ever be invaded by Allied forces in the Pacific,"(16) Betio Island, in the Tarawa Atoll, smaller than New York's Central Park, presented two major problems for American forces; it was



heavily fortified and was fringed by a thick coral reef. There were approximately 5,000 elite naval infantry forces on Betio. They were equipped with everything from tanks to 8-inch naval guns and had spent the preceding 15 months turning Betio into a fortress.

Prior to landing, Allied naval and air bombardment attempted to soften up the beachhead, but for the most part the defenses were still strong. The Japanese remained well entrenched in pill boxes and barricades within yards of the beach, waiting for the invaders, and were fanatical in their resolve to die to the last man.

### The Landings

About 125 amphibious tractors put the initial assault troops ashore. In attempting to do so, 323 of the 500 men operating the amphibious tractors were killed, wounded, or missing in action.(17) Ninety of these vehicles fell prey to enemy gunfire and were lost either in deep water, on the offshore reef, or burned as a result of gas tanks igniting. Others were wrecked on beaches by underwater mines or

succumbed to mechanical failure. When their landing boats hung up on reefs, marines had to wade about a thousands yards to shore under withering fire which decimated entire units. Moreover, the enemy prevented some units from landing until D+1 day.

### Navy Medicine Goes to Work

Four aid men landed with each assault company. In some assault companies 50 to 70 percent of the marines became casualties.(18) Because of the high volume of casualties, corpsmen could only render the most necessary first aid on the beach. They used first-aid kits and boat-bags and employed whomever they could to help evacuate the wounded to transports.

By the end of D-Day, approximately 5,000 marines had gone ashore, of which 1,500 were dead or wounded. On D-Day + 1, collecting medical companies—consisting of a medical officer, 11 hospital corpsmen, 3 marines, and 1 jeep ambulance—went ashore with the second wave of troops and began setting up evacuation points

on the beach. Transport medical sections, which also arrived that day, assisted.

Casualties were evacuated to the end of the pier, where, if necessary, they received further treatment before being transferred back to transports by boats. The majority of the wounded were brought aboard the transports within 2 hours of their injuries, but some had to wait as many as 12 hours because of heavy enemy fire.

Early casualty numbers of USS *Heywood* attest to the difficulties the attackers experienced. Upon its arrival at noon on D-day + 1, 277 marines and sailors were brought aboard for treatment.(19) The next day, two medical companies of the Second Medical Battalion came ashore and established blackout surgery areas and were ready for operations within 12 hours.

Tarawa was extremely costly to both Americans and Japanese before the enemy garrison of about 5,000 was annihilated. The victors lost 980 marines and 29 sailors died; 2,101 were wounded.(20) Hell in a very small place, a term used to describe another battle in a later war, was the most accurate assessment of the Tarawa experience. Virtually at sea level, Betio offered no cover, no shade from the blistering temperatures, no drinking water, and no relief from choking dust. Working in bunkers freshly purged of their Japanese occupants, Navy corpsmen and doctors administered treatment under hellish enemy fire. Twenty-six corpsmen and two physicians lost their lives. For their bravery, Tarawa corpsmen earned three Navy Crosses and 12 Silver Stars.



LCDR Justin Stein, MC, USNR, examines a medicine bottle left behind by the Japanese on Tarawa.



A landing barge provides transportation for two wounded marines from Tarawa. Their next stop in the evacuation chain is a troopship which will take them to a base hospital for definitive care.

## Sanitation

After the island was secured, conditions surrounding the burying of the dead, distribution and disposal of food and waste initiated sanitation problems. Decaying corpses littered the landscape. Food trash and feces had been left uncovered. There were also crater holes, garbage and trash dumps, open heads, and ration dumps. Fly- and mosquito-breeding areas were everywhere. Dysentery was the greatest threat at the time.

On 23 Nov, personnel began the slow, arduous task of burying the dead. By 3 Dec, most of the cadavers were buried, and sanitary toilets, screened galleys and mess halls, and fly traps were slowly being constructed.

On 24 Nov, hospital ship *USS Solace* rendezvoused with evacuation vessels and received 234 of Tarawa's wounded.(21) She then sailed for Hawaii, disembarked patients, and then headed for San Francisco with more patients. *USS Relief* also came to

Abemama but wasn't needed. Subsequently, she retired to Funafuti Atoll, Ellice Islands, and served as a base hospital there until January.

## Makin Taken

Troops landed at 0830 on 20 Nov on islets in the Makin Atoll and faced little resistance. Within a few days, organized resistance ceased. In seizing Makin, Army casualties were relatively low with 64 killed and 150 wounded.(22) Because casualties ashore were low, medical facilities proved adequate. Except in isolated cases, evacuation to transports was prompt and transport medical facilities were fully utilized. By 24 Nov, the majority of those wounded had been removed from clearing stations.(23) Transports put out to sea nightly about an hour before sundown and returned after sunrise. Forty patients were evacuated by flying boat to Funafuti and then to Pearl Harbor via land plane.(24)

## Problems at Sea

Before dawn on 24 Nov, Japanese submarine-launched torpedoes struck *USS Liscome Bay* (CVE-56) off Makin and it sank with great loss of life. Destroyers *USS Morris*, *USS Hughes*, and *USS Hull*, picked up the survivors. Aboard *Morris*, medical officers and corpsmen treated about 60 survivors. Most were covered with oil and were seriously burned. Aboard *Hughes*, medical personnel received survivors for about 2 hours following the carrier escort's demise. Like on *Morris*, most of the survivors were coated with fuel oil. To correct this, the medical officer set up burn teams. They consisted of two nonmedical assistants who removed oil from patients, cleansed burns, and applied sulfa powder or boric acid ointment dressing. Subsequently, pharmacist's mates carefully segregated the patients at the after dressing station. Two trained officers administered morphine and morphine tags, sulfathiazole and several first-aid treatments.

## Abemama

Once Tarawa was secured, the Second Marine Division proceeded to take Abemama which proved to be the easiest of all the operations. The Abemama operation resulted in only three American casualties—one killed and two wounded. The Japanese forces were either killed or committed suicide.(25) Abemama was secured on 26 Nov.



## Changes and Additions

The average patient census for Navy hospitals in 1943 more than doubled that of the previous year, escalating from 13,274 to 39,723.(26) Consequently, the Navy Medical Department continued to expand rapidly. Additional wards and other buildings were being constructed at existing hospitals and four base hospitals, and a mobile hospital and several dispensaries were commissioned in the closing months of 1943. In the United Kingdom, four more dispensaries, ranging from an 87-bed to a 500-bed unit, were also commissioned.

At Pearl Harbor, HI, Base Hospital No. 8 was established on 1 Nov and replaced Mob-2. Personnel from Mob-2 became part of the new base hospital while plant and equipment were transferred to USNH Aiea Heights, which had been constructed adjacent to Mob-2. Base Hospital No. 9 Oran, Algeria, was commissioned on 19 Nov with a bed capacity of 500. In Sydney, Australia, Navy medical personnel took over an Army facility and commissioned it U.S. Naval Base Hospital No. 10 on 4 Dec; on 24 Dec, the hospital unit of Cub Three on New Georgia was established as Base Hospital No. 11 Munda. Incidentally, Mob-12, destined for the Russell Islands, would not set sail in December as planned. Problems prevented the group from leaving the States until late spring 1944.

At BUMED, several divisions were reorganized in November including the administrative, planning, and finance divisions. The Navy Medical Department also established a material division to handle the procurement of medical supplies and materials. Although it was housed in the Naval Medical Supply Depot, Brooklyn, NY, it was administrated separately. BUMED also established a liaison office.

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# Fly-Away Advanced Care System

HM2(DV) Daryl F. Stanga, USN

DIVERS MAY EXPERIENCE significant injury that requires both recompression therapy and advanced life support. Many diving accidents occur in remote locations, where recompression chambers may not be equipped to provide advanced care. Additionally, there is often an extended transport time to the nearest recompression chamber, and advanced life support may be required during transit. Two of these accidents have stimulated interest in upgrading the level of care available in fleet recompression chambers. The Fly-Away Advanced Care System (FAACS) was developed at Naval Medical Research Institute (NMRI), Bethesda, MD, in response to this need.

In May 1984 an Explosive Ordnance Disposal (EOD) diver was treated aboard USS *Kittywake* for severe arterial gas embolism. The diver required ventilatory support. With no mechanical ventilator available, the inside tender used only a Bag-Valve-Mask resuscitator (AMBU bag) to ventilate. The situation was temporized when the master diver attached a demand valve to the chamber's Built-in Breathing System (BIBS) hose (the BIBS system delivers 100 percent

oxygen to a stricken patient). In this way, a crude, manually operated positive pressure ventilator was effected, which alleviated manual ventilation. But the demand valve had to be physically activated for every patient breath during the 10-hour recompression treatment. There was no control of tidal volume or respiratory rate. Only a stethoscope and sphygmodynamometer were available to monitor vital signs, and these are difficult to use with background noise in the chamber.

A similar problem occurred at Naval Station Roosevelt Roads, Puerto Rico, in 1988. A civilian diver with severe decompression sickness and respiratory distress needed recompression therapy and advanced life support. A system similar to the one used on *Kittywake* was used to ventilate the patient. The Diving Medicine Department at NMRI was contacted for assistance. NMRI's Penlon Oxford Ventilator was flown to Puerto Rico in an F-4 fighter and was modified to operate from SCUBA cylinders on-site. However, due to incompatibility of components, the ventilator piping had to be adapted to work in the chamber. Because of leaks in this setup, the SCUBA cylinder were rapidly

exhausted and had to be changed approximately every 45 minutes.

In November 1989, personnel at NMRI decided to develop a method of providing advanced care and monitoring in fleet recompression chambers. They evaluated two ways to accomplish this goal. The first would entail modification of all 58 of the Navy's recompression chambers to include a ventilator and monitoring systems. This would be very costly and take many years to develop and implement. Additionally, it would require modification and recertification of all affected chambers. The second would involve a portable system that could be transported for use in any recompression chamber. The FAACS was developed to suit that goal.

The first step in developing the FAACS was to select and evaluate advanced life support equipment that would operate in the recompression chamber during recompression therapy. The second step involved obtaining NAVSEA approval for these components in the recompression chamber. Once these two steps were completed, the unit was built. The unit centers around two primary components: the Penlon Oxford Ventilator and the Propac 106 Patient monitor.



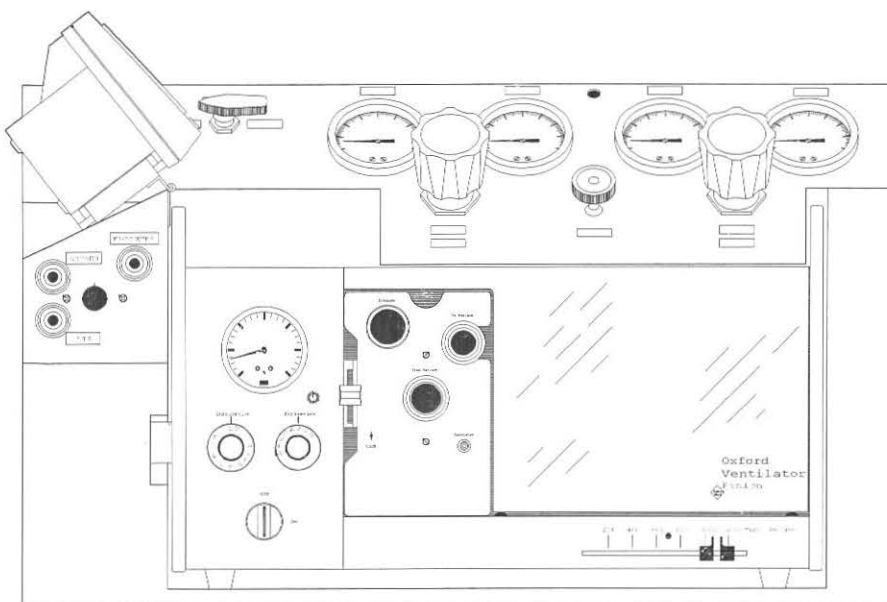


Figure 1. Front view of FAACS



Figure 2. FAACS as it would be used in a standard Navy recompression chamber.

The only power source required by the ventilator is pressurized gas of at least 50 psi provided by a set of SCUBA cylinders. Breathing gas for the patient comes from either the BIBS or from chamber air. The Propac Monitor is equipped with a 3-lead EKG, and can monitor invasive and noninvasive blood pressure and core temperature. This

monitor could operate up to 8.5 hours on its internal battery without recharging. The system also contained two means of suctioning respiratory secretions and a subsystem to dump exhaust gas from the chamber. Additionally, the FAACS has subsystems to provide humidification of patient gas, whether BIBS gas (usually 100

percent oxygen) or chamber atmosphere. All components for these systems are approved for use in Navy recompression chambers.

When all the components had been chosen, it was time to build a compact unit for easy transport and setup, wherever it was needed. Fabricated in September 1991, the prototype is 24 inches long, 15 inches high, 15 inches deep, and weighs 80 pounds when fully assembled. These dimensions make it small enough to fit into any standard Navy recompression chamber. Because of its versatility, this system can be used when transporting a victim to a recompression chamber, as well as inside the chamber.

Testing began at NMRI/DMD in October 1991. These tests showed that one set of twin-80 SCUBA cylinders will operate the ventilator for an entire Navy Treatment Table 6. This table is the most commonly used treatment therapy for decompression sickness; it is approximately 5 hours in duration.

Features of the FAACS:

- Provides a ventilator, suction, and vital functions monitor in a self-contained package.
- Lightweight and easily transportable worldwide to remote locations.
- Can be used in any Navy recompression chamber.
- Operates independent of a recompression chamber.
- Uses only one set of SCUBA cylinders for an entire Navy Treatment Table 6.

When deployed to the fleet, the FAACS will greatly enhance the medical care available to the injured diver who requires advanced life support during recompression treatment. □

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HM2(DV) Stanga is on staff at the Diving Medicine Department, Naval Medical Research Institute, Bethesda, MD.

## **Notes and Announcements**

### **Needed—First Person Accounts**

The Historian of the Navy Medical Department, Jan Herman, is collecting first-hand accounts and conducting oral histories of Navy medical personnel to help fill gaps in the written historical record. The Navy Medical Department's long history has created many experiences and exciting stories. Moreover, these stories often contain precious tidbits of history. Therefore, Mr. Herman requests that Navy medical personnel, both retirees and active duty, record their experiences.

There are two ways to convey your story, taped or written. Taped versions should be on a normal cassette. First-hand accounts should be typed; please limit your story to 15 pages of double-spaced text. For a good example of a first-hand account, refer to the article "Dorothy Still Danner: Reminiscences of a Nurse POW" in the May-June 1992 issue of *Navy Medicine*. Even though you may not be a historian, or have doubts about your writing ability, don't let this deter you from contributing. If you have had a worthwhile experience, let us know and we will take it from there.

Of particular interest are stories concerning wars, conflicts, and overseas deployments. Experiences such as World War II, Korea, and Vietnam are of primary interest. Nevertheless, recent deployments such as Grenada, Panama, and the Persian Gulf have not been adequately documented.

Anecdotes which provide some form of compelling insight into Navy medicine are also welcome. The stories can be humorous, but dramatic pieces which are emotionally moving are also welcome.

Regardless of the medium or subject, be sure to focus on your interesting experience. Mr. Herman is also willing to conduct oral history interviews. His careful questioning will help organize your thoughts and ideas.

Mr. Herman can be reached at: Bureau of Medicine and Surgery (MED-09H), 2300 E Street N.W., Washington, DC 20372-5300. Telephone: (202) 653-1297, DSN 294-1297.

### **Occupational Health Workshop**

The Navy Environmental Health Center will sponsor the 35th Navy Occupational Health and Preventive Medicine Workshop from 26 Feb to 4 March 1994 in Virginia Beach, VA.

Military and civilian occupational health, preventive medicine, environmental health, and safety professionals are encouraged to attend this workshop. The theme is Environment, Health, and Safety: Achieving the Balance.

There is no registration fee. The workshop has been approved for Continuing Education credits. Abstract submission forms can be requested from the Navy Environmental Health Center. Submissions must be received at the Center by 7 Jan 1994.

For additional information contact: Ms. Marianne Schwartz (NEHC-04B), Navy Environmental Health Center, 2510 Walmer Avenue, Norfolk, VA 23513-2617. Telephone: DSN 564-7575, ext 461 or Commercial (804) 444-7575, ext. 461. □

## **To the Editor**

### **Autotransfusion**

I would like to respond to your article "Autotransfusion Technique Saves Navy Hospital a Bundle" published in the July-August 1993 issue of *Navy Medicine*.

While the article is well written it is also quite misleading as to where the Navy is with autotransfusion. At the National Naval Medical Center [NNMC, Bethesda, MD] we have been actively using this technique for many years. At NNMC we have three autologous blood recovery units. We presently use these units in our open heart, orthopaedic, and vascular surgery programs. At our facility the Navy operating room nurses are responsible for the program.

As for a combat role, has anyone bothered to look at what is sitting on our hospital ships? Yes, we do have autotransfusion units on both of the white hulls. We recognized many years ago the limitations of having blood available to the troops in the theater of operations. While not a substitute for all of the patient's blood requirements it can certainly lessen the amount that the blood bank would have to have on hand. A combat consideration, however, is that this technology certainly requires other elements to support it (i.e., electricity and large volumes of normal saline to wash the blood with). While acceptable for some operational platforms it is not suitable for others.

While I commend Dr. Potter for his efforts at Oak Knoll the Navy as a whole has done a great deal to utilize this valuable technology. Least of all are the Navy operating room nurses who have been in the business for many years.

LCDR T.C. Stewart, NC □

## **In Memoriam**

RADM John W. Albrittain, MC (Ret.), former Deputy Surgeon General of the Navy, died 20 Sept 1993 of cardiopulmonary arrest at Kensington Gardens Nursing Home in Kensington, MD.





RADM J.W. Albrightain, MC

RADM Albrightain was born in La Plata, MD, on 30 April 1911. He completed both his undergraduate and medical studies at the University of Maryland, receiving his medical degree in 1935. After completing his internship and residency in 1939, Dr. Albrightain entered active duty with the Navy in 1940. During World War II, he served in numerous posts, including Naval Hospital,

Quantico, VA; U.S. Naval Air Station, San Juan, PR; the Naval Dispensary, Washington, DC; and aboard USS *Wyoming* as senior medical officer in 1945.

In 1946, Dr. Albrightain began 3 years of residency training in dermatology at Naval Hospital, St. Albans, NY, and the New York Skin and Cancer Unit of New York University. Upon completing this residency, he qualified as a diplomate of the American Board of Dermatology and was assigned to Naval Hospital, Long Beach, CA, as a dermatologist. He then moved on to Naval Hospital,

Portsmouth, VA, where he eventually became Chief of Dermatology Service. In March of 1953, he reported for duty as medical officer on USS *Iowa*, and after this tour was assigned to Naval Hospital, Bethesda, MD, as the dermatologist.

In May 1959, he reported to the Chief of the Bureau of Medicine and Surgery for duty as Head, Medical Corps Training. In June 1962, Dr. Albrightain was assigned to Naval Hospital, Portsmouth, VA, as executive officer. In January 1965, he assumed command of Naval Hospital, St. Albans, NY, and on 1 July 1966, he was promoted to rear admiral. He then assumed command of the Naval Hospital and Naval Hospital Corps School, Great Lakes, IL.

In February 1969, Admiral Albrightain assumed duties as Deputy Surgeon General of the Navy and Deputy Chief, Bureau of Medicine and Surgery. On 1 March 1973, he retired from the naval service.

Admiral Albrightain was awarded the Legion of Merit for the performance of his duties as Deputy Surgeon General. In addition, his military decorations include the American Defense Service Medal, American Campaign Medal, World War II Victory Medal, Navy Occupation Service Medal with Europe Clasp, and the National Defense Service medal with one Bronze Star. □

Photo by HM2 Dan Kelly, NSHS, Bethesda, MD



**All Under One Roof:** Six retired Surgeons General visit BUMED for the Sixth Annual Navy Medical Department Leaders' Conference. (Left to right) VADM Lewis H. Seaton, VADM Willard P. Arentzen, VADM George M. Davis, VADM Hagen, VADM Donald L. Custis, VADM J. William Cox, and VADM James A. Zimble.

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BUMED Archives

**(Left to right) Miss World—Miss USA Lynda Carter; Miss San Diego, Priscilla Barnes; and Miss Maryland, Betty Jo Grove accompany Bob Hope and spread Christmas cheer at the National Naval Medical Center, Bethesda, MD.**

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